Appendix 11

Referral Form (Sample Format)

Client's Name: _____ Date of Referral: _____
Medicaid ID Number:_____ Address_____
Birthdate:_____ _____
Telephone Number:_____ _____

Referral To: [*Service provider's name, address, and telephone number*]

_____

_____

_____

Referred By: [*Service provider's name, address, and telephone number*]

_____

_____

_____

Reason for Referral: _____

_____

_____

_____

Authorization: I, _____ [*Client's Name*], give my permission to _____ [*Service Provider's Name*], to release this information to _____ [*Care Coordination Provider's Name*]. The information is to be used to assist me in monitoring and coordinating my health care and social service needs.

Signature of client/parent or guardian: _____

Date: _____

Service Provider's Reply (summary of findings, diagnosis, recommendations, comments, as appropriate):

Signature: _____ Date: _____